

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/21/2013
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00134528.</p> <p>Complaint IN00134528 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 21, 2013</p> <p>Facility number: 000538 Provider number: 155620 AIM number: 100267290</p> <p>Survey team; Shannon Pietraszewski, RN-TC Census bed type: SNF: 14 SNF/NF: 149 Residential: 70 Total: 233</p> <p>Census payor type: Medicare: 22 Medicaid: 119 Private: 87 Other: 5 Total: 233</p> <p>Sample: Residential: 1</p> <p>Zionsville Meadows was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00134528.</p> <p>Quality review completed on 08/24/2013 by Brenda Marshall Nunan, RN.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE